Patient Demographics

Name: _____ Date of Birth: _____ Age: _____

Male ☐ Female ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐

Social Security Number: _____ How did you find us?: _____

Who is your primary care doctor? _____

Home/Mailing Address: _____ City: _____

State: _____ Zip Code: _____ E-mail Address: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Would you like access to our **online** patient portal, where you can request appointments, request prescription refills, make payments on your account, and send messages to our office? *(Please circle)* Y / N

Preferred Method of Contact: Home Phone ☐ Cell Phone ☐ Patient Portal ☐ Letter ☐

Preferred Language: _____ Ethnicity: _____

Emergency Contact

Full Name: _____ Relationship: _____ Phone: (_____)_____

Primary Insurance Information

Primary Insurance_____

ID # _____ Group # _____

Subscriber Name: _____ Subscriber DOB: _____ Relation to Pt: _____

Secondary Insurance Information

Primary Insurance_____

ID # _____ Group # _____

Subscriber Name: _____ Subscriber DOB: _____ Relation to Pt: _____

I certify that I (and/or my dependent(s)) have insurance coverage with the above named insurance company and assign directly to the selected provider of South Bay Vascular Center and Vein Clinic all insurance benefits, if any, payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the provider to release information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. My signature certifies I have received the HIPPA information.

I give permission for Dr. Kokinos and staff to call me by phone, e-mail, voicemail message, and/or postal mail to confirm appointments and provide me with other information related to my health.

Name (Please Print): _____ Signature: _____ Date: _____

South Bay Vascular Center & Vein Institute
PREMIER CENTER OF EXCELLENCE

Phone: 408-376-3626 Fax: 408-871-2377
Web: SouthBayVascular.com
Locations: Campbell • Gilroy

Financial Policy

Thank you for choosing us as your health care provider. The following is a statement of our *Financial Policy*, which we require that you read and sign prior to any treatment. All patients must complete and sign the appropriate documents.

YOUR INSURANCE COMPANY REQUIRES PROOF OF INSURANCE BE PRESENTED FOR ALL SERVICES PROVIDED. IF PROOF OF INSURANCE IS NOT PRESENTED, REGRETTABLY, PAYMENT AT THE TIME OF SERVICE WILL BE REQUIRED. IT IS THE RESPONSIBILITY OF EACH PATIENT TO INFORM US OF ANY CHANGES IN INSURANCE, PLACE OF EMPLOYMENT, AND/OR ADDRESS AND PHONE NUMBERS. WE WILL REQUEST A PATIENT INFORMATION UPDATE TO BE COMPLETED ONCE A YEAR. ALL COPAYS MUST BE PAID AT THE TIME OF SERVICE.

PPO: Our office submits a claim to your insurance company. The balance after your insurance payment is your responsibility. Please pay all copays and deductibles at the time of service.

HMO: Our office will submit an insurance claim to your insurance company. Obtaining an initial authorization for services is the responsibility of the patient and/or referring physician's office. If an authorization is not obtained, charges will be the responsibility of the patient at the time of the appointment. Please be aware that HMOs require our office to collect all non-covered services and copays from the patient.

Private Insurance: Our office will bill your services to your primary insurance company as a courtesy. Full payment is due at the time of service if benefits are not verified or proof of insurance is not presented. Any balance not covered by insurance after 60 days is considered due and payable.

Patients Without Insurance: Full payment is due at the time of service. Payment arrangements are available if coordinated with our business office prior to the visit.

Missed Appointments: Unless cancelled at least 48 hours in advance, our policy is to charge for missed office appointments. The charge is $50.00. Please help us serve you better by keeping scheduled appointments.

Copies Of Medical Records: There is a charge for copying medical records. There is a fee of $0.45 per page copied, plus reasonable clerical fees of $24.00/hour (charged in quarter hour increments), which includes the time spent in locating, acquiring and copying the actual records, plus postage fees. The records will not be sent until the fee is paid. These fees are set by the State of California (Health & Safety Code section 123110), not the South Bay Vascular Center or the Institute for Vascular Testing.

Phone Calls: It is not the office policy to call patients with test results. If you request a phone call, the charge will be $25.00 for every fifteen minutes.

Cosmetic Fees: Payments made for cosmetic consult may be applied to cosmetic treatment up to 6 months after the initial consult.

Interest is charged at 8% per year on accounts with a patient responsibility balance.

I have read, understand, and agree to the contents of this Financial Policy.

Name (Please Print): _____ Signature: _____ Date: _____

South Bay Vascular Center & Vein Institute
PREMIER CENTER OF EXCELLENCE

Phone: 408-376-3626 Fax: 408-871-2377
Web: SouthBayVascular.com
Locations: Campbell • Gilroy

Acknowledgement of Privacy Practices
& Privileged Medical Information

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications
- Call home, work, or cell phone to confirm or reschedule appointments
- Leave a message on answering machine

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of its *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I, _____, give South Bay Vascular Center permission to speak to the family members and/or friends listed below regarding my privileged medical information. I may change and update my list whenever I wish by submitting a request to the office in writing.

Name of person	**Relationship**
_____	_____
_____	_____
_____	_____

☐ NOT APPLICABLE

Name (Please Print): _____ Signature: _____ Date: _____

Signature:_____

South Bay Vascular Center & Vein Institute
PREMIER CENTER OF EXCELLENCE

Phone: 408-376-3626 Fax: 408-871-2377
Web: SouthBayVascular.com
Locations: Campbell • Gilroy